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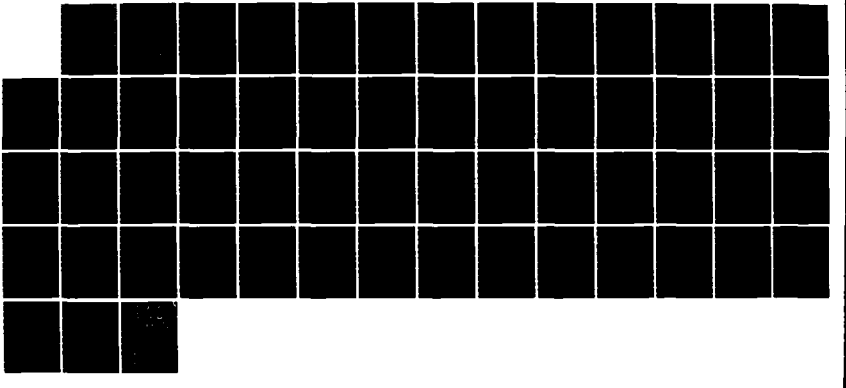

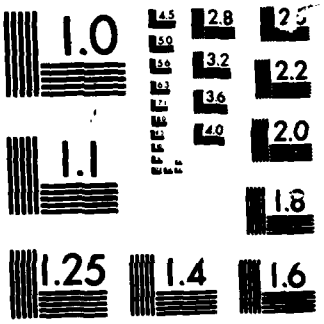

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STUDENT REPORT

USAF ALCOHOL ABUSE CONTROL:
DOES IT MEET THE NEEDS OF
THE MILITARY FAMILY?

MAJOR HIROSHI AJAS 86-0040

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REPORT NUMBER 86-0040

TITLE USAF ALCOHOL ABUSE CONTROL: DOES IT MEET THE NEEDS OF THE MILITARY FAMILY?

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requirements for graduation.

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Alcohol abuse and alcoholism continue to be one of our most pressing health problems. Not only is the alcoholic debilitated by the "disease" of alcoholism but also those who are intimately close to him/her--the family. Since alcoholism is a family disease, the goal of Air Force rehabilitation programs should be to treat not only the alcoholic but also his/her family as well. The study analyzes the problem associated with treating the family of the military alcoholic, and also investigates Air Force efforts to identify, educate, and treat the family affected by alcoholism. The study concludes that the Air Force has resources available to take care of the needs of family members dependent/addicted to alcohol, and families of alcoholics. However, there is still room for improvement.

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PREFACE

Alcohol abuse is America's number one "killer!" It directly affects over 9-10 million people, yearly. Not only is the alcoholic debilitated by the "disease" of alcoholism but also those who are intimately close to him/her--the family.

The alcoholics' families make up another 36 million more who are "trapped" by the effects of alcoholism. Recent studies on the alcoholic's family concluded that alcoholism or alcohol abuse contributed, either directly or indirectly, to an unhealthy (dysfunctional) family environment. The family is therefore considered just as "sick or sicker" than the alcoholic. Overall, these families experienced a disappropriately higher number of separations and divorces, spouse abuses, child abuses and neglects, suicides, and other forms of domestic violence.

Historically, the focus of treatment has been on the alcoholic, and not on the family. As a result, the family, unfortunately, is usually left out in the "cold", having to fend for themselves. The general consensus among alcoholism counselors is that in order to help the alcoholic recover from the "disease", the family must also recover. Therefore, the goal of rehabilitation programs is to place equal emphasis on treating both the alcoholic and his/her family.

With this goal in mind, the author attempts to not only investigate the problems facing the alcoholic's family, but also, what efforts, if any, are being taken by the Air Force to treat the family. The research project describes the overall scope of the alcohol problem, past and present Air Force efforts to help the alcoholic's family, and how civilian and Air Force rehabilitation programs compare in their rehabilitation philosophy (treatment models) and approaches (treatment settings, therapeutic techniques and philosophies) used on the alcoholic's family. The overall purpose of this research project is to develop recommendations to assist Air Force planners in broadening their effort to help military families affected by alcoholism.

The author is deeply indebted to Major Laurel Henderson, HQ AU/DPZ, for taking the time from her busy schedule to give me expert advice and guidance on this sensitive subject, and Lt Colonel Lytle E. Allen, III., Assistant for Social Actions, HQ AU/DPZ, for sponsoring this research project. My appreciation also extends to the following Social Actions and Family Support Center staff members for providing me valuable information and professional advice: Lt Colonel Sal Curto, HQ USAF Social Actions Office; Captain Terry Riley, HQ AFMPC Social Actions Office; Captain James Lockwood, HQ PACAF Social Actions Office; Mrs. Valerie Biltz, Director of Family Support Center and Mrs. Carol B. Beason, Family Support Center Social Worker, at Maxwell AFB, Alabama; and Mr. Jerry Pinson, Lackland AFB Social Actions Office. Finally, special thanks to my research advisor, Major Stephen L. Havron, ACSC/EDOWA, for keeping me on the right track, and Major John P. Lockney, Faculty Instructor (Seminar 36), for providing me "constructive" criticism of this paper.

ABOUT THE AUTHOR

Major Hiroshi Ajas received his commission through AFROTC at East Carolina University in 1972. In his 13 years in the United States Air Force, he has performed a variety of duties at both base and Major Command (MAJCOM) levels. His assignments include: Human/Race Relations Instructor and Chief of Drug/Alcohol Abuse Control at Loring AFB Social Actions Office, Maine; MAJCOM Social Actions Staff Officer and Assistant for Social Actions (DPZ), Deputy Chief of Staff/Manpower and Personnel, at Headquarters Air Force Logistics Command, Wright-Patterson AFB, Ohio; Chief of Customer Assistance Section, Chief of Personnel Readiness Unit, and Chief of Career Progression Section at Wright-Patterson AFB Consolidated Base Personnel Office (CBPO); and Chief of CBPO and Chief of Personnel Division (DP) at Altus AFB, Oklahoma.

Major Ajas possesses a Bachelor of Science degree in Biology from East Carolina University, Greenville, North Carolina; a Bachelor of Arts degree in Behavioral Science (Psychology) from University of Maine, Presque Isle, Maine; and a Masters of Science degree in Mental Health Counseling from Wright State University, Dayton, Ohio. He is a National Board Certified Counselor, a licensed alcoholism counselor in Ohio, and a licensed secondary education science teacher in North Carolina. He is a graduate of Squadron Officer School in residence, and completed Air Command and Staff College (ACSC) by correspondence. Presently, he is attending ACSC, with a graduation date of 6 June 1986.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS

TABLES

EXECUTIVE SUMMARY

Part of our College mission is distribution of the students' problem solving products to DoD sponsors and other interested agencies to enhance insight into contemporary, defense related issues. While the College has accepted this product as meeting academic requirements for graduation, the views and opinions expressed or implied are solely those of the author and should not be construed as carrying official sanction.

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REPORT NUMBER 86-0040

AUTHOR(S) MAJOR HIROSHI AJAS, USAF

TITLE USAF ALCOHOL ABUSE CONTROL: DOES IT MEET THE NEEDS OF THE MILITARY FAMILY?

1. Purpose: To analyze the problem associated with treating the family of the military alcoholic, and to investigate Air Force efforts to identify, educate, and treat the family affected by alcoholism.

2. Problem: Historically, the focus of treatment has been on the alcoholic, and not on the family. As a result, family members, who are affected by the disease of alcoholism, are basically ignored in the treatment process of the alcoholic. To help the alcoholic recover from alcoholism, his/her family should be included in the overall treatment program. The Air Force Alcohol Abuse Control Program, therefore, may not be meeting the needs (education and treatment) of the alcoholic's family.

3. Objectives: To examine the scope of the alcohol problem (Nationwide and Air Force-wide) and its affect on the family; to investigate the past and present Air Force efforts to help the alcoholic's family; to examine and compare Air Force and civilian alcohol rehabilitation programs' philosophy and treatment approaches used on families of alcoholics; and to develop recommendations to assist Air Force planners in broadening their effort to help families affected by alcoholism.

3. Discussion of Analysis: The author has limited the research project to only examine and compare efforts taken by the Air Force Alcohol Abuse Control Program and selected civilian rehabilitation programs for the family of the alcoholic. It is not the intent of this paper to investigate the effort taken by military and civilian sectors to identify, educate, and treat the alcoholic. Various studies (e.g., RAND, Burt Associates,

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System Development Corporation, NIAAA, Department of Health and Human Services) have already addressed this area. Additionally, a definitive conclusion as to the effectiveness (i.e., success rates, relapse rates, follow-up care, etc.) of the Air Force and selected civilian rehabilitation programs involving families of alcoholics could not be made based on the time constraints imposed by the Air Command and Staff College to complete this research project. The findings, conclusions, and recommendations were based on the author's review of the literature, response from Air Force program (Family Support Center, Social Actions, Family Matters office) directors and managers at base, Major Commands, Air Force Manpower and Personnel Center, and Air Staff levels, and personal experiences and/or observations of the operation of the Air Force and civilian rehabilitation programs.

4. Findings: The following findings are made: (1) the types of problems experienced by families of alcoholics in the civilian communities are similar to those experienced in military communities, (2) Air Force rehabilitation programs are not attracting many families to participate in the recovery process of their spouses who are admitted for treatment, (3) very few families experiencing alcohol problems are evaluated or referred for treatment, either on or off base, and (4) the exact number of family members requiring treatment for alcohol problems, and families of alcoholics participating in Alcohol Rehabilitation Centers and Social Actions programs cannot be determined.

5. Conclusions: The following conclusions are made: (1) alcohol abuse and alcoholism continue to be a significant health problem in the United States, (2) Air Force and DOD have taken great interest in assisting both family members dependent/addicted to alcohol, and families of alcoholics, (3) review of selected Air Force and civilian rehabilitation programs support, in general, that considerable similarities exist in the rehabilitation philosophy and treatment approaches applied to alcoholic family members and families of alcoholics, (4) alcohol abuse education participation of military families has continued to decline, (5) Family Support Centers (FSCs) are providing referrals and minimum counseling to families affected by alcoholism; however, the number of family members counseled or referred to on and off base agencies is not tracked, and (6) the Family Assistance and Support Team (FAST) program is not adopted on all bases.

6. Recommendations: Overall, the Air Force has resources available to take care of the needs of family members dependent/addicted to alcohol, and families of alcoholics. However, the following recommendations are made to improve the Alcohol Abuse Control Program: (1) Air Force should renew their emphasis to educate the military family by encouraging participation in base and local community sponsored alcohol abuse education seminars and courses, (2) incorporate or expand existing education and training courses to emphasize the family disease concept, (3) require FSCs to track the number of family members requiring assistance for alcohol-related problems; add this data into the drug/alcohol statistical summary so Air Force Alcohol Abuse Control Program's administrators and planners can better assess the impact alcohol abuse or alcoholism has on military families, (4) evaluate the effectiveness of the FAST program to determine if

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it is still a viable program; for bases having FSCs, determine if they are really meeting the objectives set forth in the FAST concept, (5) increase alcoholics' families participation in the treatment program by requiring clients' spouses to attend the intake interviews, and either change the requirement to obtain client's written permission before his/her family can be contacted to participate in the program or research this problem to find a suitable alternative, (6) establish an Air Staff Ad Hoc Task Group to review the problem of getting families affected by alcoholism to seek help from either on or off base agencies, with the goal of improving the overall "quality of life", and (7) revise the drug/alcohol statistical summary to include data concerning the number of families counseled and referred for treatment from Family Support Centers.

Chapter One

INTRODUCTION

"Alcoholism is a family disease. When someone develops alcoholism, the family develops their own co-addiction, an emotional illness. For the alcoholic to recover, the family's got to recover" (25:10). This quote from Pat Snyder, family counselor at the Navy's Alcoholism Rehabilitation Center in Norfolk, Virginia, illustrates the addictive, destructive nature of alcoholism and the need to not only treat the alcoholic but the family as well. According to Sharon Wegscheider, president of ONSITE Training and Consulting, there are millions of families in the United States who are "trapped by the stigma and warped by the effects of alcoholism" (16:12). In fact, of the estimated 9 million alcoholics in the United States, there exist another 36 million family members whose lives have been significantly affected by the disease of alcoholism (29:9). In essence, "alcoholics and other drug users take hostages of those that love them" (21:69).

It is common knowledge among alcoholism counselors that the alcoholic's family is just as sick or sicker than the alcoholic (10:119). The family, in an attempt to cope with the problems presented by the alcoholic, feels guilty and ashamed for the behavior of the alcoholic. They begin to isolate themselves from friends and other social supports in an attempt to conceal the problem. In general, the family experiences feelings of inadequacy and failure for not being able to control the alcoholic's drinking (10:117). An adult, that was a child of an alcoholic, states, "In our family there were two very clear rules. The first was that there is nothing wrong here, and the second was, don't tell anyone" (41:2).

Sharon Wegscheider explains the effect a chemically dependent person has on the stability of the family by first describing how a non-chemically dependent family reacts to life stresses (i.e., death, illness, separation). She makes an analogy between the family's attempts to maintain stability and the operation of a mobile:

> A family resembles a mobile. A mobile is an art form made up of rods and string upon which are hung various parts. The beauty of the mobile is in its balance and flexibility. The mobile has a way of responding to changing circumstances such as wind. It changes position but always maintains connections with each part. If I flick one of the suspended parts and give it kinetic energy, the whole system moves to gradually bring itself to equilibrium. The same thing is true of a family. In a family where there is stress, the whole organism shifts to bring balance, stability or survival (9:39).

In a chemically dependent family, Wegscheider explains that each family member is affected by the chemical abuser and "in an attempt to maintain balance, members compulsively repress their feelings and develop survival behaviors and walls of defense to protect them from pain" (9:40).

Margaret Heckler, former Secretary of Health and Human Services, further explains the disruptive effects alcohol has on the family. She cites a 1982 survey in which one in three Americans considered alcohol as causing considerable family problems. In addition, she points out several adverse social consequences of alcoholism. Problems such as divorce and separation were seven times higher than the general population and two out of five domestic cases going to court involve alcohol. Also, alcoholism and excessive drinking may be involved in spouse abuse, child abuse and neglect, rapes, suicides, and other forms of family violence (48:--).

The military family, a microcosm of the general population, has not escaped the affects of alcoholism. In a 1977 RAND study, approximately 14% of Air Force military members were identified as experiencing severe problems with alcohol. One of the alcohol-related problems dealt with interpersonal relationships of the alcohol abusing member. The study found 5% of these members had some form of interpersonal relations' problems, such as fights, or their spouse either left or threatened to leave (2:2,4). Burt Associates' study (1980) identified 7% (144,000) of military members as being alcohol dependent; 83% (12,672) of the respondent admitted to drinking alcohol at least occasionally (4:21,24). Additionally, 2.2% of the married respondents said a family member needed help for drug or alcohol abuse. This percentage equates to approximately 29,500 to 36,000 family members (28:17). The most recent RAND study (1982) found 88% of AF members drank alcohol with 33% drinking moderately to heavy (26:279).

In response to Burt Associates' finding that many family members needed help for drug and alcohol abuse, James Holcomb, Director of Assessment and Research, Office of the Assistant Secretary of Defense for Health Affairs, said, "From the answers of the survey respondent, it is evident that many dependents need help but are not getting it, at least in Government programs" (28:17).

The need to treat the family of the alcoholic is clear when you consider the debilitating effect alcoholism has on all family members:

> All the character defects of the alcoholic rub off on his family. His loneliness separates the usual family rapport. His secretiveness alienates family members. His shame will not permit him to share with his loved ones. The bottle has been his constant companion for years. Faced with the shame and insecurity and lack of trust of the alcoholic, his family many times goes into a shell--almost in self-defense. So often the family feels responsible for the alcoholic's drinking. The family faces two grim situations: its own blame and the repudiation of its love by the alcoholic. The alcoholic is not only imprisoned with his own disease but the family is imprisoned in its own particular type of cell block (13:249).

STATEMENT OF THE PROBLEM

The general consensus among civilian and military rehabilitation counselors is that alcoholism is a family disease. The Air Force recognizes alcoholism as a family illness (61:3). The Institute for Addictive Illnesses, a civilian alcohol/drug abuse outpatient service located in Dayton, Ohio, notes the effect alcoholism has on the family: "not only the chemically dependent person suffers because of his disease; his family members and others close to him or her are often tragically affected by the

troubled person's addiction" (67:--). The problem with various rehabilitation programs is the focus on treatment is placed on the alcoholic member, the family is basically ignored. By incorporating family members into the treatment process with the alcoholic, the success rate of the alcoholic has increased 30 to 50 percent (12:119).

This research project paper will focus on the problem associated with treating the family of the military alcoholic. Furthermore, the author will examine and compare Air Force Alcohol Rehabilitation Program's philosophy and treatment approaches with civilian alcohol programs to determine if improvements can be made to treat the family, not just the alcoholic member.

OBJECTIVES

The objectives of this research project are: (1) to examine the scope of the alcohol problem and its affect on the family, (2) to investigate the past and present efforts taken by the Air Force to help the alcoholic's family, (3) to examine and compare Air Force rehabilitation programs' philosophy and treatment approaches, as it applies to the family, with civilian rehabilitation programs, and (4) to develop recommendations to assist Air Force planners in broadening their effort to help the family affected by alcoholism.

LIMITATIONS

The author has limited the research project to only examine and compare the efforts taken by the Air Force Alcohol Abuse Control Program and selected civilian rehabilitation programs for the family of the alcoholic. It is not the intent of this paper to investigate the effort taken by military and civilian sectors to identify, educate and rehabilitate the alcoholic. Various studies (RAND, Burt Associates, System Development Corporation) have already evaluated the effectiveness and efficiency of the Alcohol Abuse Control Program for the military member. Additionally, the following limitations apply in determining the exact number of military dependents participating in or requiring alcohol treatment programs: (1) no records available to determine how many Air Force dependents participated in off-base civilian treatment programs, (2) lack of accurate records by both on and off base agencies to determine the number of dependents referred to community alcohol treatment programs, (3) previous RAND studies did not specifically ask the respondents the exact number of dependents requiring treatment for alcoholism; only counted the number of respondents who felt someone in their family needed help for alcoholism, and (4) the FY 84 USAF Drug/Alcohol Statistical Summary, provided by the Air Force Social Actions Operations Division, only tracked families using rehabilitation services (counseling, referrals) by units, and not by number of dependents. The time constraints imposed by the Air Command and Staff College also limited the time available to complete this research project.

DEFINITIONS

The following definitions consist of terms used within the context of the Air Force Alcohol Abuse Control Program and selected civilian treatment programs. Terms unique to this research project paper are also defined.

1. Alcoholism. "A progressive, non-compensable [illegible] disease that affects the entire family and is both preventable and treatable; widely [illegible] as a family illness" (63:1,3).

A disease characterized by "pathological dependency on ethanol [illegible] under Section 303.2 in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association" (36:2).

A disease characterized by "physical dependence and inability to control drinking" (3:3).

"An illness or disorder characterized by some loss of control over [illegible] habituation or addiction to the drug alcohol, or causing interference in [illegible] function: for example, health, job, family, friends or the law" (12:10).

2. Alcoholic. A person medically diagnosed as suffering from the effects of alcoholism (63:3-2).

3. Alcohol Abuse. "The repeated drinking of alcohol that consistently interferes with the individual's physical, emotional, social, economic, family, school, or community functioning" (34:14).

4. Alcohol Dependent. A person who experiences one or more of the following symptoms within a year period: (1) tremors, (2) morning drinking, (3) impaired control, and (4) blackouts (4:24).

An individual who has lost control over alcohol use and generally requires use of alcohol to prevent withdrawal symptoms (2:3).

5. Alcohol Abuse Control Program. A formal Air Force program established to prevent, educate, identify and rehabilitate alcohol abusers. The program guidelines are contained in AFR 30-2 (63:3-1).

6. Alcohol Rehabilitation Program. A formal Air Force treatment program for alcohol abusers consisting of local programs by Social Actions, centralized programs at Air Force Alcohol Rehabilitation Centers and referrals to other agencies (63:3-1).

7. Chemical Dependency. An individual who is addictive to either alcohol or other drugs (16:18).

8. Chemically Dependent Family. "It is a system of related concerned persons who are hurting and in crisis. Within this family, there is self-delusion, compulsive behavior patterns and a growing primary disease of chemical dependency" (14:17).

9. Concerned Person. An individual (i.e., spouse, other family member, friend, worker) who is concerned about the abusive drinking of the alcoholic; able to describe problems such as deteriorating marital relationship, financial difficulties, or work impairments (14:1).

10. Codependency. "A pattern of immature adaptive mechanisms that exist in alcoholics, many spouses of alcoholics and children of alcoholics" (22:42).

"A specific condition characterized by preoccupation and extreme dependence on another person--emotionally, socially, and sometimes physically. This dependence, nurtured over a long period of time, becomes a pathological condition that affects the codependent in all other relationships" (46:4).

ORGANIZATION

The research project consists of five chapters. Chapter One contains a brief introduction of the problem of alcoholism and its affect on the family, statement of the problem, limitations, definition of terms, and organization of the project. Chapter Two contains information on the scope of the alcohol problem nationwide and in the Air Force. Additionally, the impact alcoholism has on the family is further examined. Chapter Three contains background information on past and present Air Force efforts to educate, identify, and treat families affected by alcoholism. Chapter Four examines and compares Air Force and civilian rehabilitation programs' philosophy and treatment approaches used to help the family. Finally, Chapter Five contains: (1) the author's conclusions and findings on the problems associated with treating the family of the alcoholic, and (2) recommendations for Air Force planners to better assist military families of the alcoholics based on the examination and comparison of Air Force and civilian rehabilitation programs.

Chapter Two

SCOPE OF THE PROBLEM

NATIONWIDE TRENDS

Alcohol abuse and alcoholism continue to be one of the most significant, social/medical problems affecting the nation. It is common knowledge among alcoholism counselors and medical professionals that alcoholism is the third most important public health problem following heart disease and cancer. The disease of alcoholism directly affects approximately 10 million people. In addition, a great number of deaths previously attributed to accidents and physical illnesses such as liver and heart diseases, acute pancreatitis, malnutrition, and pneumonia are now considered alcohol-related deaths. By including these deaths into the overall total, alcohol abuse suddenly becomes America's number one "killer" (12:24,28).

The price this society pays in terms of economic cost, human suffering, disease and death is alarmingly high (48:v). According to the American Business Men's Research Foundation, the national cost of alcohol problems reached an all time high of $61 billion in 1979 (18:--). A significant portion of this amount, approximately $28 billion, was due to loss of productivity of employees affected with alcoholism. The second largest cost, over $18 billion, went towards various alcohol-related health care; hospital cost being the largest ($12 billion). To put it simply, $1 out of every $5 spent for hospital service involved treatment of alcohol-related illness (18:--). On the average, the economic cost of alcohol abuse has been estimated at over $49 billion a year (48:v). The human cost in terms of pain and suffering resulting from alcohol abuse is incalculable. The Fifth Special Report to the U.S. Congress on Alcohol and Health, prepared by the office of the Secretary of Health and Human Services in 1983, highlighted some of the adverse, social consequences of alcohol abuse:

1. Traffic accidents are the fifth leading cause of death in the United States. In 1981, over 199,000 people were killed or permanently disabled as a result of traffic accidents--and up to half of these were alcohol-related.

2. At least 8,000 pedestrians are killed and another 100,000 injured each year by motor vehicles. In one recent study, more than a third (36%) of injured pedestrians and nearly half (45%) of those who died from being struck by a motor vehicle had blood alcohol concentrations above .10%[legally intoxicated].

3. Alcohol is also a factor in aviation accidents. In 678 fatal plane crashes nationwide in 1979, alcohol impairment was identified in 30 pilots, most of whom had BACs above .10%.

4. In 1980, 22,800 persons died and another 90,000 were permanently injured in home accidents. Recent studies suggest that alcohol may have contributed to some of these accidents.

5. Alcohol use is considered one of several contributing causes of over 23,000 murders committed in the United States in 1980.

6. In 1981, 82,088 rapes were reported. Several studies indicate alcohol consumption and rape may be associated; however, the role of alcohol in rapes is still poorly understood.

7. The Fourth Special Report noted as high as four out of five of those who attempt suicide had been drinking at the time. Also, alcoholics commit suicide from 6 to 15 times more frequently than the general population (48:--).

In addition to the adverse effects alcoholism has on society and to the alcoholic member, it further affects the family. For example, forty percent of all domestic problems brought to court involve some form of alcohol abuse (10:114). Additionally, an estimated 33% to 40% of alcoholic couples experience marital problems. And, the rate of separation and divorce among alcoholic couples is seven times that of the general population (48:89). The most significant problem affecting alcoholics' families is domestic violence: spouse abuse, child abuse, and neglect.

Several studies on family violence link alcohol abuse with spouse abuse. According to Maria Roy, founder of Abused Women's Aid in Crisis (AWAIC) in New York City, over 80% of cases AWAIC handled in 1976 involved husband's abuse of alcohol and other drugs. Furthermore, she found these abusing men "seemed to beat their wives more often both when drunk or sober," and, "very often, the assaults came during sobriety" (27:4). A Minnesota study of 100 abused wives who called a local community "hotline" found that 35% of the abusing men were daily drinkers and another 10% were weekend drinkers. Also, an Ann Arbor, Michigan study found that of the women who sought emergency aid for spouse abuse, 60% of them reported that their husbands drank excessively, and 66% of the total assaults involved alcohol (49:91). Finally, Dr. Eli Breger, former Chief of Psychiatric Service at the Naval Hospital in Beaufort, South Carolina, report several spouse abuse studies indicate about "half the victims claimed their husbands or manfriends were frequently drunk and most often violence occurred when the man was under the influence" (20:5).

As with spouse abuse, child abuse and neglect is also found to be linked with alcohol abuse. The National Center on Child Abuse and Neglect estimates there are approximately one million cases of child abuse and neglect each year, and of these, 200,000 involve assaults. According to the American Humane Association, 17% of child abuse or neglect cases occurring nationwide between 1974 to 1976 involved alcohol abuse (27:3). Further studies even suggest that one-third of all reported cases of child abuse involve alcohol abuse (49:91). In addition to physical abuse, many children of alcoholic families suffer other problems. These problems include various types of psychological and emotional impairments (i.e., stress, depression, anxiety), impaired school performance, hyperactivity, enuresis (bed wetting), stress-related illness, and suicide (38:1). Furthermore, these children are much more likely to develop alcohol problems in the future. One report estimates there are 28 to 34 million children raised in alcoholic homes; and of these, 50% will become alcoholics and 30% will marry alcoholics (38:3).

AIR FORCE—WIDE TRENDS

In 1977, RAND Corporation studied the prevalence of alcohol problems in the Air Force. They found over 14% of Air Force personnel experienced serious alcohol problems with about 5% exhibiting the symptoms of alcoholism. These rates were also found to be comparable to civilian populations (2:2). In 1980, Burt Associates conducted a worldwide survey of alcohol use among military personnel. Their study showed 4% of Air Force personnel (7% DOD-wide) were alcohol dependent. Additionally, of the 4,156 Air Force respondents, 1% (415) admitted to physically striking their spouse or children while under the influence of alcohol (4:Table 21,Table 22). The most recent worldwide survey, conducted by the Research Triangle Institute (1983), indicates alcohol abuse was rising among the active duty military while drug abuse was decreasing (35:21). This finding compares with the latest alcohol/drug abuse statistics compiled by the Social Actions Office at the Air Force Manpower and Personnel Center. In their FY 84 USAF Drug and Alcohol Abuse Control Statistical Summary, they conclude: "alcohol abuse identification rate continues to increase compared to FY 1982," while the "total drug identification decreased 19.4% compared to 4th quarter FY 83 data." In FY 84, the total number of alcohol abuse identification was 8,234 (7666 had families) as compared to the FY 82 figure for 7,051 (64:3,6,21). Additionally, a total of 17,968 personnel were evaluated to determine the extent of their alcohol problems (64:6).

The negative impact alcohol abuse has on the Air Force is similar (except unique requirements such as Personnel Reliability Program, etc.) as those in the civilian population. For example, the estimated cost of alcohol problems to the Air Force in 1977 was $62.4 million. The largest single cost, over $27 million, was attributed to lost production. The second largest cost, over $21 million, was for loss of medical care; the bulk of this amount, $15.8 million, went directly to hospitals for treatment of alcohol-related illnesses or accidents (11:37). Most recent information, provided by the Social Actions office at HQ AFMPC, revealed some startling figures: (1) 87.4% of Air Force personnel drink alcohol, (2) 156 alcohol-related, off-duty vehicle fatalities occurred in FY 84 (FY 84:4), (3) 28% of the Air Force members reported diminished work performance as a result of alcohol abuse in 1982, and (4) rehabilitation costs the Air Force $7.5 million (73:--).

A strong relationship exists between family violence and alcohol abuse (27:2-11). The military family, unfortunately, has not escaped the family violence which pervades society. Recent DOD Family Advocacy Committee Statistical Report, (See Table 1.) shows over 13,000 cases of child abuse/neglect and spouse abuse were reported DOD-wide in FY 84 (1st & 2nd Qtrs). In the Air Force, 367 child abuse/neglect and 1,828 spouse abuse cases were reported (53:Table 4). By accepting the premise that half of all spouse abuse (32:5) and one-third of all child abuse/neglect cases (49:91) involved alcohol abuse, then the number of Air Force families abused by alcoholics total over 1,200. Furthermore, this figure may even be higher since incidents of this nature are often difficult to detect and many are not reported (53:16-1).

SUMMARY

Review of current alcohol literatures and studies indicates the problem of alcohol abuse and alcoholism is still great. Both the nation and the Air Force continue to pay dearly in terms of economic cost, loss of human lives, and the pain and suffering experienced by those close to the alcoholic. The nature of the alcoholism

CASES OF FAMILY VIOLENCE, BY SERVICE,
FY 84 CHILD ABUSE AND NEGLECT

	Physical Abuse	Neglect	Abuse and Neglect	Sexual Abuse	Emotional Maltreatment	Other Abuse
(Quarters 1-2)						
Air Force	182	123	5	49	8	0
Army	1,580	1,660	517	835	152	0
Navy	577	421	389	160	48	0
Subtotals	2,339	2,204	911	1,044	208	0

	Deaths	Total Child Abuse and Neglect	Spouse Abuse/ Deaths	Total Child Abuse and Neglect and Spouse Abuse
Air Force	0	367	1,828/0	
Army	14	4,758	2,078/2	
Navy	4	1,599	2,533/0	
Subtotals	18	6,724	6,439/2	13,163

(Source: US Department of the Air Force. Family Support Center Resource Manual. The Pentagon, Washington, DC: HQ USAF/MPXHF, no date, p. 16-5.)

Table 1. Cases of Family Violence

disease affects not only the alcoholic but also the entire family. The following chapter will provide a brief background of the Air Force Alcohol Abuse Control Program to include past and present Air Force efforts to meet the needs of the military family.

Chapter Three

AIR FORCE EFFORTS TO ASSIST THE MILITARY FAMILY

BACKGROUND

The first big push to treat Air Force alcoholics began in 1966 with the initial test of the Alcohol Treatment Center at Wright-Patterson AFB, Ohio. This center was the forerunner of the present Air Force Alcohol Rehabilitation Program. Wright-Patterson's Alcohol Treatment Center continued to serve as the primary program to treat alcoholics until 1972, when the Air Force Alcohol Abuse Control Program, managed by Social Actions offices, was established on 140 Air Force bases worldwide (11:6).

The establishment of the Air Force Alcohol Abuse Control Program was in response to DOD Directive 1010.2, "Alcohol Abuse by Personnel of the Department of Defense (1972)." In 1973, the program's operating instructions were covered in a Personnel regulation, AFR 30-23, "USAF Alcohol Abuse Control and Rehabilitation," and subsequently, superseded in 1974 with the publication of AFR 30-2, "Social Actions Program" (most recent update: 22 June 1981). AFR 30-2 specifically covers the operation of the base-level outpatient program (Social Actions' Drug/Alcohol Rehabilitation Program). The Air Force Medical Services (1974) published an accompanying regulation that covers the operation of the Air Force Alcohol Treatment Centers: AFR 160-36, "Rehabilitation of Personnel With Drinking Problems" (35:12). The most current AFR 160-36 is dated 20 July 1981.

In 1976, General David C. Jones, former Chief of Staff, emphasized his commitment to reduce the deleterious effects of alcoholism. In a letter to all Major Command commanders, he stated, "The total cost of alcoholism to the nation is estimated at $25 billion a year. Lost work time alone has been computed at $9.35 billion a year. The human loss to individuals, families and communities is incalculable" (56:--). To combat this growing threat, he instructed the Air Force to come up with innovative methods to prevent and deter alcohol abuse, deglamorize alcohol use, identify and rehabilitate alcohol abusers, and educate the force on the negative effects of alcoholism. Thus, an Ad Hoc Task Group was formed. The task group developed 15 initiatives that included assistance to Air Force families of alcoholics. The family assistance initiative contained the following:

- Development and distribution of a Family Assistance Package which
  - -- emphasized alcoholism as a family illness,
  - -- described the role of the alcohol specialist, and
  - -- described when, how, and the purpose of establishing initial contact with family members of the alcoholic;
  - -- availability of various referral services (i.e., chaplain, Social Actions, medical staff), and

-- information on inpatient Alcohol Treatment Centers.

- Implementation of a comprehensive prevention program to unite the resources of local installations and communities:

  -- Distribution of alcohol abuse literature and reading materials to bases.
  -- Counseling service to assist families in various areas: child abuse, drug/alcohol abuse, financial aid, spiritual, and marriage problems; counseling service to provide information on the alcohol abuse control program and treatment regimen.
  -- Development and distribution of preventative education programs such as "Alcohol Awareness Seminar," and "The Power of Positive Parenting."
  -- Development of a total community resource referral listing describing: service, type of programs, costs, operating hours and identification of helping agencies like Al-Anon Family Groups, Alateen Groups, Alcoholics Anonymous, child/spouse abuse support groups, and Parent Effectiveness Groups.
  -- Establishment of hotlines and telephone counseling services to help families in crises (55:17,18).

In 1978, the DOD continued its efforts to tackle alcohol/drug abuse problems in the Services. The former Deputy Secretary of Defense Charles Duncan, speaking before the House Select Committee on Narcotics Abuse and Control, introduced 12 initiatives for "stimulating needed improvement and constructive change [in Services' alcohol/drug abuse control programs] and reinforcing program effectiveness and emphasis at the highest levels of authority." The goal was to "strengthen each of the seven major functions of the Drug/Alcohol Abuse Control Program: Prevention (Law Enforcement and Education), Identification, Training, Treatment/Rehabilitation, Research, Evaluation and Planning/Coordination" (54:Attachment 5). Included in the 12 initiatives were plans to improve the drug/alcohol education/prevention programs for the military family, and a recommendation to eliminate the space-available policy for families desiring treatment in military rehabilitation programs. Additionally, it emphasized the family's use of community-based programs to promote self-identification of drug/alcohol abuse problems, and to take advantage of their extensive prevention/education programs. Finally, the DOD Directive 1010.2 was amended to include the needs of the military family (54:Attachment 5).

CURRENT AIR FORCE EFFORTS

In 1980, the White House Conference on Families considered alcohol and drug abuse the second most pressing problem facing families in the United States. As a result, Congress directed all Services to expand their existing alcohol/drug abuse programs to better meet the needs of families of alcohol/drug abusers. The result was the policy implemented by DOD Directive 1010.4, "Alcohol and Drug Abuse by DOD Personnel." The directive stated, ". . . that programs and standards of care for families must be consistent with those for our military members" (59:Attachment 6).

As a result of the above action, the 1980 Air Force Conference on Families, held at HQ AFMPC, Randolph AFB, Texas, developed several initiatives to improve the

quality of life for Air Force families. One of the initiatives addressed the needs of families of alcohol abusers. This initiative, which became part of the Air Force Action Plan for the 1980's, recommended the use of Family Assistance and Support Teams to help family members with alcohol, drug, and domestic violence problems. Most importantly, it established the need for base-level Family Support Centers to serve as a referral agent for Air Force families. Another initiative tasked the Leadership and Management Development Center (LMDC), Maxwell AFB, Alabama, to develop a recurring survey to capture family attitudes and perceptions about the Air Force (17:8,9). The author found in a recently developed LMDC survey (yet to be released), entitled, "USAF Family Survey, a question concerning the prevalence of drug/alcohol problems: "I believe there are more drug and alcohol problems in the Air Force community than in the outside community" (60:5). Responses to this question will put to rest, once and for all, whether drug/alcohol problems are more prevalent in military communities versus civilian communities.

Family Assistance and Support Team

In a 1981 letter to all Major Command Chief of Staffs, General Andrew P. Iosue, then USAF Deputy Chief of Staff, Manpower and Personnel, announced the establishment of the Family Assistance and Support Team (FAST). He stated the objective of the FAST program is "to improve the assistance provided Air Force families in which problems related to alcohol or drug abuse are present." Also, to accomplish this would require, "melding existing resources (chaplain, physician or mental health professional, drug/alcohol abuse control specialist) into a team which can effectively address the total family illness associated with abuse" (57:--).

The operation and purpose of the FAST are as follows:

> 1. FAST provides a convenient mechanism through which the principal assistance providers can know which Air Force members and their families are receiving assistance for alcohol or drug related problems and can coordinate the assistance provided to avoid needless duplication of services. At no time during this process will the chaplain's counselor/counselee confidentiality be violated. Involving the chaplain, medical/mental health and alcohol/drug specialists in the team does not violate any regulatory requirements as all members are involved in the Air Force rehabilitation milieu [setting].
>
> 2. The purpose of the FAST is to:
>
> a. Provide educational information that facilitates early intervention in families in which alcohol or other drug abuse problems are present.
> b. Assess the nature and scope of family problems related to alcohol or other drug abuse.
> c. Work effectively with family groups.
> d. Assist in the reconciliation, adjustment/alteration of relationships and resolution of problems within intact Air Force families which have been disrupted by alcohol or other drug abuse.
> e. Provide appropriate aftercare and follow-up techniques that assist Air Force members and their families, in which an alcohol or other drug abuse is present, in long term problem resolution.

f. Elicit support of potential local referral agents, e.g., security police, unit commanders, physicians, emergency room personnel, mental health personnel, youth program directors, school counselors, chaplains, etc.
g. Utilize their individual strengths and expertise in building an effective family treatment team (59:Attachment 6).

The revised AFR 30-2 (1981) regulation established the FAST program.

Family Support Center

In presenting the USAF's Fiscal Year 1985 Report to the Congress, former Secretary of the Air Force, Verne Orr, and Chief of Staff of the Air Force, General Charles A. Gabriel, expressed their support for base-level Family Support Centers (FSCs). The FSCs provide "centralized, one-stop service to family members," with the purpose of supplying "information, referral and coordination, including PCS relocation assistance, spouse employment information, aid for families in crisis [substance abuse, physical abuse], support during family separation, financial management education, programs for special needs and family development education" (24:10).

The idea for having Family Support Centers (FSC) originated from the 1980 Air Force Conference on Families (17:8), and several studies (Families in Blue, 1980; Leadership Perspective on Air Force Family Life, 1981; and Families in Blue: Phase II, 1982) conducted in the early 1980's (53:5-1). The studies validated the need for an agency that could assist families, in a non-threatening environment, to "cope with special problems associated with military life" (53:7-5). Additionally, FSCs could perform a liaison function with drug/alcohol programs, and for programs involving domestic violence (spouse/child abuse). The "crisis intervention and referral role of FSC's is most critical in those areas [substance abuse, physical abuse] in which the time elapsed from onset of problem to initiation of treatment is a critical factor for personal and family intergration" (53:5-8).

In his speech to the National Military Family Association (June, 1985), Mr. Orr reiterated the importance of having FSCs by saying they "serve a preventive role," and it is a place "where families can go to help themselves" (24:10).

Educational Efforts

Since the establishment of Social Actions' Alcohol Abuse Control Programs in 1972, the alcohol education training programs have undergone several major changes. In addition to curriculum changes, the number of dependents (voluntary participation) attending these courses slowly began to decline. Initially, the number of dependents attending the Alcohol Abuse Education (2-hour) course was relatively high (i.e., 45,961 (Jan 73-Jun 74); 40,994 (Jul 74-Dec 75); 8,733 (Jan-Jun 76). However, when the combined Drug/Alcohol Awareness Seminar (4-hour) replaced the Alcohol Abuse Education course in July 1976, fewer dependents attended this course (i.e., 10,596 (Jul-Dec 76); 6,309 (Jan-Jun 77); 3,894 (Jul-Sep 77). A special Alcohol Awareness Seminar (8-hour) was implemented in 1976 to support the Concerned Drinkers Program. This program concentrated on educating individuals involved in alcohol-related incidents, and those interested in learning more about alcoholism. Further decline in dependent participation was seen in this program (i.e., 392 (Jul-Dec 76); 249 (Jan-Jun 77); 234 (Jul-Sep 77) (65:20).

Presently, Social Actions offers two Drug/Alcohol Education Seminars (2 hour each)--one for commanders/supervisors and the other for non-supervisors. Again, the number of family members attending these classes continued to decline sharply (4,243 in FY 1981 to 268 in FY 1984). Alcohol Awareness Seminars are still offered on most bases; however, Air Force no longer tracks the number of active duty members or dependents' attendance (64:5).

The Air Force continues to provide several on-going training programs for personnel (drug/alcohol counselors, medical staff, chaplains, etc.) involved directly with the Air Force Alcohol Abuse Control Program. For example, in 1984, 181 service representatives attended the Johnson Institute seminars and training programs. The Johnson Institute programs covered:

> . . . alcohol abuse, other drug use, and effects of substance abuse on the family. Programs cover the complexities of substance abuse and family systems, assessment tools, victimization, sexuality with alcohol and other drugs, early recognition of alcohol and other drug dependence, family reactions, enabling behavior and its effects on the person harmfully involved with alcohol and other drugs, intervention techniques and methods, treatment goals, and approaches to family aftercare (32:5).

The Lackland Technical Training Center at Lackland AFB, Texas, has developed an advanced drug/alcohol abuse control course for Social Actions drug/alcohol counselors (implementation date unknown). The course outline contains:

> . . . basic concepts of family functioning and methods of rehabilitation, outlining the nuclear family, family homeostasis, family rules, family subsystems and boundaries as key elements. . . major theories of family functioning [to include] communication model, systems model, structural model, and the social learning model. Address theories of etiology of family dysfunction. . . . Explain the family evaluation procedure [to include] evaluator observations, reports from the family and evaluation assessment. . . . (52:7).

The Air Force Advance Course on Family and Substance Abuse is another course offered to Major Commands and base-level drug/alcohol counselors, and Family Matters/Family Support Center staffs. The first course was taught in Minneapolis, Minnesota, in September 1985. The course covered such topics as drug/alcohol, Family Advocacy, assessment and intervention techniques, stress management, family systems, family violence, and case study reports (58:--).

In April 1985, the first Commander's Spouse Training Course was offered to commanders' spouse. A review of the course outline contained information on drug/alcohol abuse and family crisis:

> Drug and Alcohol. To become aware of the dynamics surrounding drug and alcohol issues. To know what resources are available to those involved in drug and alcohol abuse and the methods for accessing them.
>
> Family Crisis. To become aware of the various types of family crises; and to develop skills for coping with crises of others as well as with the commander's family. To know the resources that are available to families

involved in a crisis and how to access those resources (23:7).

SUMMARY

With the establishment of the Air Force Alcohol Abuse Control Program in 1972, DOD and Air Force developed several initiatives to expand alcohol/drug abuse control programs. Several initiatives were developed to assist families in the areas of alcohol abuse prevention, identification, education and treatment. In addition to Social Actions alcohol abuse education and treatment programs, families can now seek assistance from Family Assistance and Support Teams and Family Support Centers. To improve assistance to families in crisis (drug/alcohol abuse, spouse/child abuse, financial, etc.), Air Force has sponsored many courses on the troubled family. Many individuals in the "helping" profession (drug/alcohol counselors, chaplains, FSC staff, FAST members) and concerned persons (i.e., commanders' wives) have attended these courses.

Chapter Four

PROGRAM TREATMENT PHILOSOPHY AND APPROACHES

INTRODUCTION

In this chapter, the author examines and compares Air Force and civilian rehabilitation programs' philosophy (based on treatment models) and treatment approaches (to include treatment settings, therapeutic philosophies and techniques). The objective is to determine if current Air Force programs for families of alcoholics are similar or different than civilian programs, and how are they similar or different.

The author selected the following civilian rehabilitation programs for study: the Greene Memorial Hospital's Chemical Dependency Unit (Greene Hall) in Xenia, Ohio; the Institute for Addictive Illnesses (IAI) in Dayton, Ohio; and the Nebraska Division on Alcoholism and Drug Abuse prevention/treatment program called Children from Alcoholic Families. The reason for selecting Greene Hall and IAI was due, in part, to they being representative of civilian programs. Another reason is the author's familiarity with the operation of the two programs. He worked as a volunteer counselor in Greene Hall, and as a graduate student counselor at IAI. The Children from Alcoholic Families is representative of programs aimed at treating a specific group.

OVERVIEW OF CIVILIAN REHABILITATION PROGRAMS

Rehabilitation Philosophy

The civilian rehabilitation programs' philosophy is predicated on the type of treatment model selected (43:--; 1:22-23; 9:3-14). In essence, a treatment model denotes how alcoholism is defined or viewed, the types of techniques used to treat alcoholism, and what outcomes are expected from established therapeutic goals (1:22). The rehabilitation program's philosophy, therefore, is based on the specific model adopted.

The medical model views alcoholism as a disease. Since this model is based on the disease concept of alcoholism, medical intervention is normally the preferred method of treatment (43:268). The alcoholic is perceived to have a physical condition that "renders him chronically ill and forever vulnerable to alcohol." Therefore, the alcoholic cannot be cured; however, he/she can be rehabilitated and the disease controlled (1:22). Most treatment professionals who accept this philosophy state the only therapeutic goal an alcoholic should strive for is total abstinence (1:22). The therapeutic techniques include various forms of psychotherapy (1:102), and use of antipsychotic agents (to control anxiety) and/or disulfiram (Antabuse) to deter alcohol use (43:268).

The behavioral modification model focuses on changing the drinking behavior of

the alcoholic. In other words, the reason an individual drinks alcohol excessively is because it is learned and reinforced as a behavior that brings rewards (50:75; 43:269). In the book Alcohol Abuse and Rehabilitation Approaches, authors John Cull and Richard Hardy note, "Alcoholism is maintained through positive reinforcement resulting from the anesthetic properties of alcohol," and that "individuals who are under environmental stress are more likely to drink alcohol for the anesthetic effects as compared to those individuals who experience less stress, since alcohol would have a weak reinforcing value" (6:49). The therapeutic goals are to find out how the alcohol is reinforcing to the individual, and why. Hopefully, through behavioral therapies, individuals can eliminate the learned behaviors associated with drinking, and thus acquire more effective, positive behaviors (free of alcohol). The therapeutic techniques include, but are not limited to, systematic desensitization, aversion therapy, combined aversion and relaxation therapies, use of chemicals (i.e., Antabuse) and assertiveness training (51:152).

The psychological model views alcoholism as a "manifestation" of "pathological symptoms" (1:23). The treatment approach, therefore, is "not aimed solely at the symptomatic behavior but rather seeks to uncover the intrapsychic [psychological] conflicts. . . ." (1:19-21,23). The therapeutic techniques include psychoanalytic therapy, transactional analysis, gestalt therapy and counseling from recovered alcoholics (43:272). The therapeutic goals are to help alcoholics gain insight into the underlying causes for their drinking, and to surface these causes so they can resolve them in a rational way (5:13). The therapists who adhere to this model consider it a necessity for the alcoholic to either give up drinking alcohol completely, or practice controlled drinking (3:87).

The social model identifies alcoholism as being caused by "social factors which result in psychological dependence" (43:274). The social factors may include cultural or ethnic values (or stresses) that promote excessive drinking, role-modeling of alcoholic parents, and instability or crisis within the family (1:20,23). The therapeutic techniques include social rehabilitation, educational and vocational training, counseling by ex-alcoholics, job counseling, milieu therapy and AA (43:274-275; 1:23). The therapeutic goals are to effect changes in social situations that cause or support individuals to drink excessively (1:23).

The Alcoholics Anonymous model considers alcoholism as an "incurable, progressive disease that will result in death without therapeutic intervention." The goal of treatment, therefore, is complete abstinence of alcohol. "Once an alcoholic, always an alcoholic--no cure is possible, only remission." And, ". . . no one can cure his or her own alcoholism without help" (9:17). The model consists of following the Twelve Steps of AA; establishing an environment that is open and free to exchange intimate, personal experiences; establishing a close fellowship with other alcoholics; and most important, being able to talk in confidence (anonymous) with others without feeling guilty or ashamed (43:276). The AA program is considered by each member to be a life-long treatment program: "alcoholic is always recovering but never recovered. . .," and, ". . . a member is always potentially a drinker, however long he has been sober" (43:277).

Finally, the multivariant model is a combination of several models (43:276; 9:28-29). It does not believe in the premise that all alcoholics are basically the same, and display the same dysfunctions (impairments). What the model does infer is alcohol abuse affects each individual differently, and there is a varying degree of alcohol

dependence, ranging from acute addiction to problem drinking (43:276). Since the model incorporates other models, the techniques used also vary.

In summary, some rehabilitation programs' philosophies are based on a specific model; others use a combination of each. According to Gary Lawson, James Peterson and Ann Lawson, authors of Alcoholism and the Family, "no one model is universally 'true' or appropriate and that all the models. . . can be effective, depending on the unique needs of the client." In addition, "Many models of treatment can be adopted to focus on the family system (as opposed to the individual) as the client" (9:29). In response to what type of treatment goal an alcoholic should seek, most alcoholism counselors still consider abstinence as the primary goal (44:51; 1:28; 49:111).

Treatment Approaches

A treatment "approach" encompasses the treatment setting, a therapeutic philosophy, and techniques. In general, the treatment approach practiced in the civilian sector is usually based on one of two treatment methods (1:23). One method is to use a single "modality" (or method) to treat alcoholic patients. The technique employed in this method includes one of the following: disulfiram, client-centered therapy, psychoanalysis or Transactional Analysis, and others. Another method is to expose the alcoholic to a wide variety of techniques (didactic instructions on alcoholism, individual and/or group therapy, etc.) with the hope that "something" will work (1:23). In an article titled "Alcoholism: An Overview of Treatment Models and Methods," Dr. Sugerman assessed the effectiveness of the two methods: ". . . there is little evidence that any one approach is more effective than any other when applied globally to the heterogeneous population of alcoholics as they appear after recovery from withdrawal" (43:276). Additionally, he notes major changes have occurred in treatment programs where patients are matched with specific and appropriate treatment settings, staff and techniques (43:277).

Treatment Setting. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), most, if not all, programs fall into one of three major treatment settings.

1. Hospital Setting

   a. Inpatient hospital--traditional 24-hour/day service, based on a medical model but often including psychotherapy as well.
   b. Partial hospitalization--day care in a hospital setting (not 24-hour/day), allowing the patient to go home or to work at appropriate times.
   c. Detoxification--a short "drying out" period for patients with serious toxic symptoms (i.e., delirium tremens), usually custodial in nature but occasionally including emergency medical measures.

2. Intermediate Setting

   a. Halfway house--a total-milieu facility providing living quarters and ancillary services (job counseling, psychotherapy, etc.) for patients in need of extended care but not requiring hospital treatment.
   b. Quarterway house--a facility similar to a halfway house, but offering more intensive, often physical, care under more structured

conditions.
c. Residential care--a facility providing living quarters but little or no other therapy.

3. Outpatient Setting

a. Individual counseling--treatment sessions given by a paraprofessional (i.e., someone without a graduate degree in psychology, medicine, social work, or a similar relevant field).
b. Individual therapy--treatment sessions given by professional (someone who holds a relevant graduate degree).
c. Group counseling--group sessions given by a paraprofessional.
d. Group therapy--group sessions given by a professional (1:102).

Therapeutic Philosophy and Techniques. Based on the author's reviews of several civilian rehabilitation programs, the therapeutic philosophy varies according to the techniques employed. However, review of the literature suggests that no one technique is better than another. It appears that all techniques are equally effective; they all help the patient/client (1:25,34; 12:239; 44:49; 43:277; 9:28). The key is to match the right patient/client to the right therapeutic technique(s) to reach the desired goal(s) (9:28; 1:25; 44: 49; 43:277).

"A notable advance in the treatment of alcoholism has been the recognition that, in many cases, family interaction factors play a significant role in the chronic drinking problems of a family member" (1:27). One of the many treatment techniques used on families of alcoholics is family therapy. The Fourth Special Report to Congress on Alcohol and Health (1981), reports, "Over the last 5 yrs, there has been a slight increase in the use of family therapy in the treatment of alcoholism" (49:153). Dr. Peter Steinglass, one of the leading figures in the field of alcoholism research, attests to the importance of family therapy: "Given the growing evidence that the family both plays a significant role in the maintenance of alcoholism and can influence treatment outcomes, it is not surprising that family treatment techniques have been gaining in popularity over the past two decades" (42:316).

The objectives of family therapy are to: (1) get the whole family in the treatment process, (2) remove the alcohol from the family environment (45:929; 33:--), and (3) treat the whole family as a unit instead of as a separate entity (9:--; 42:316-317; 31:400,403; 39:30; 8:150).

The types of family therapies most often practiced in the civilian sector are concurrent therapy groups for alcoholics and spouses, conjoint family therapy, multiple family group therapy, and the use of Al-Anon and Alateen groups (8:147-182; 42:316-317; 1:27). In an article "Alcoholism and the Family," Dr. Steinglass identifies the purpose of each type of family therapy. The first technique, concurrent therapy group, focuses on treating the entire family--the "patient" is not only the alcoholic, but also each family member. The second technique, conjoint family therapy, involves "interaction, communication, performance, and redefinition of problems in the family rather than individual terms." This therapy is used most often in outpatient settings. The third technique, multiple family therapy group, involves participation of several other families in a group therapy setting. Finally, many treatment programs incorporate Al-Anon and Alateen groups as part of their total treatment program (42:317).

The therapeutic goals for families of alcoholics vary according to the techniques employed; however, the process used to achieve these goals have been adopted by most programs from the workings of Virginia Satir, author of the book Conjoint Family Therapy. She states "by focusing on family interaction, communication and relating, self-discovery and sensitivity to others [family members]," then it is possible for the family to deal with their problems (31:403). The Day Treatment of the Ontario Alcoholism and Drug Addiction Research Foundation has worked extensively with alcoholics' families. Their therapeutic goals serve as an example: ". . . (1) achieving a clearer definition of conflicts, (2) opening up communication about dormant interpersonal conflicts, (3) lifting concealed intrapsychic conflict to the level of interpersonal conflicts, and (4) activating an improved level of complementarity in family role relations" (31:404).

In summary, the treatment "approach" used by civilian programs are based on types of treatment settings (e.g., inpatient versus outpatient), and adoption of one or more therapeutic philosophies based on the types of therapeutic techniques used on their patients/clients.

EXAMINATION OF CIVILIAN REHABILITATION PROGRAMS

Greene Memorial Hospital's Chemical Dependency Unit (Greene Hall)

Greene Hall is a comprehensive rehabilitation program. It has both inpatient (residential rehabilitation) and outpatient programs, and detoxification. Their rehabilitation philosophy is best described as "multivariant" (medical, psychological, AA and social models). Greene Hall considers alcoholism a disease; therefore, treatment involves three aspects of the disease: "physical, psychological, and spiritual" (66:--). The treatment approach involves the care for the physical life (from doctors, nurses and others on the medical staff), the mental life (through lectures and films), and the emotional life (through group therapies, AA, Al-Anon, Alateen, etc.). In addition, it has adopted the concept of "milieu therapy"; whereby, each patient is responsible for planning various type of activities (i.e., recreational, social), and supporting each other throughout the treatment process (1:24).

The overall therapeutic goal is to educate the person to "handle everyday living problems without the use of chemicals" (66:--). The therapeutic techniques include, but are not limited to, individual/group therapy, family therapy, recreational therapy, psychodrama, aftercare groups, AA, Al-Anon and Alateen groups. After the patient completes the intensive phase (inpatient) of the rehabilitation program, the patient and his/her spouse attend an outpatient aftercare group. A brief description of types of treatment programs available for families are as follows:

Group/Family Therapy. Both family/group therapy is "reality" based in everyday living situations, and problems associated with alcoholism are discussed in the "here-and-now" (gestalt terminology referring to the present). Normally, groups are large (averaging 15 patients); heterogeneous as to age, sex, and marital status; and homogeneous in that all participants share a common problem--alcoholism. The therapy groups adhere to Johnson Institute's goal: "To discover ourselves and others as feeling persons and to identify the defenses that prevent this discovery" (7:118).

Psychodrama. A variety of therapeutic techniques exist to reduce the individual's tension, to gain insight into his/her behavior, and to increase self-esteem

(37:11). Psychodrama is just one of many techniques available in Greene Hall. Psychodrama participants not only include recovering/recovered alcoholics but also spouses. A typical group might include a psychodramatist, counselors, several patients, and spouses of alcoholics. Dr. Shelia B. Blume, unit chief for alcoholism at the Central Islip Psychiatric Center in New York, describes psychodrama as a "variety of group psychotherapy that depends on spontaneous and immediate action, and a useful therapeutic adjunct in the rehabilitation of men and women suffering from alcoholism" (37:11). The aim of psychodrama is to "achieve a free expression of feelings in a setting which is similar to fantasy, but possesses reality as to require attention and effort on the part of the actors" and, "not only do patients release their thoughts and feelings but the psychodramatic session may initiate experiences that facilitate later discussion and analysis with an individual therapist" (15:281).

Family Aftercare Groups. In Greene Hall, the family aftercare groups are held every Tuesday night with trained counselors. The group the author participated in was large, averaging 20 people from several families. The group's goals are to allow both the recovering alcoholic and his family to continue their personal "growth"; to discuss openly each others "feelings" on how alcohol has affected their lives; and to work towards a healthy family environment. Overall, each group member attempts to discover himself/herself at a feeling level, and to "combine these insights for the benefit of both" (7:88). The aftercare groups help recovering alcoholics and their families adjust to their environments (e.g., home, work) following discharge from the inpatient program.

Didactic Groups. The didactic group's goal is to help alcoholics and their family acquire the knowledge to maintain and improve their physical and mental well being. During the session, the alcoholic is made aware that something is wrong with his/her way of life, and is taught how he/she can change it. The greatest advantage of didactic groups is that people (spouses, children, alcoholics) affected by alcoholism are seen as "students" instead of as patients (3:143). Each member is much more receptive to learn about his/her problems with alcohol (3:144). The didactic groups the author participated in covered such topics as the "Family Disease of Alcoholism," "Disease Concept of Alcoholism," and the Johnson Institute's "Feeling Chart" (describes the stages of alcoholism). Also, films like "I'll Quit Tomorrow," and guided discussions on such subjects as intervention process, AA and Al-Anon, serve to add to the educational process (66:--).

Al-Anon, Alateen Groups. Al-Anon and Alateen is a "self-help," volunteer program which incorporates the basic concepts of AA. "The sole qualification for membership is that their lives have been or are being deeply affected by close contact with an alcoholic" (30:1062). The goal of Al-Anon and Alateen is to assist alcoholics face their problems, and to see how their behaviors create an unhealthy family environment (9:19). The groups do not provide easy solutions to problems, but help each family member find his/her own answers by sharing personal experiences with others (10:234). The Twelve Steps of Al-Anon are very similar to the ones used by AA (See Table 2.).

In summary, the Greene Hall program encourages the entire family to actively participate in the alcoholic's recovery process. Briefly, the schedule of activities for the family is as follows:

- Family Orientation: Prior to attending treatment programs with the

THE TWELVE STEPS OF AL-ANON

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understand Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made a direct amends to such people whenever possible except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as a result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.

(Source: Kaufman, Edward and Pauline Kaufmann. Family Therapy. New York: St. Martin's Press, Inc., 1982, p. 177.)

Table 2. The Twelve Steps of Al-Anon

patient, the family must attend the orientation program which includes lectures on the family illness of chemical dependency and an introduction to group therapy.

-- Sundays: Al-Anon meetings scheduled every other week. On alternate weeks, families and patients view films and attend Physicians' lectures.

-- Mondays: Families encouraged to attend open AA meetings.

-- Tuesdays: After patients are discharged from the hospital, during the Aftercare Phase, families and patients attend family therapy groups.

-- Thursdays: Families are required to attend Al-Anon and Alateen groups while patients attend the closed AA Discussion Group (66:--).

Institute for Addictive Illnesses

The Institute for Addictive Illnesses (IAI) operates a comprehensive outpatient drug/alcohol treatment program, six days a week. The organization's rehabilitation philosophy is a combination of three models (AA, psychological, and social). The therapeutic philosophy is based on defining alcoholism as a disease, and as an illness which is "characterized by significant physiological, psychological, and social dysfunctions" (67:--). The IAI staff consists of paraprofessionals (many who are recovered alcoholics) who work under the supervision of consulting physicians, psychiatrists, and psychologists. The IAI has adopted a "holistic" approach to treatment of chemically dependent (drug/alcohol abuse) persons (67:--). "This approach assumes that problems are rooted within the entire family unit and each family member plays a role in the problem development." Therefore, each family member is viewed as a "patient" (39:30).

The IAI provides the following treatment programs for chemically dependent people and their families:

Day Care Program. . . . allows individuals to enter a structured treatment environment on an outpatient basis, while continuing to work at least part-time and to live at home. Adolescents and adults enrolled in this program attend sessions five days a week for a period of five to six weeks. . . comprehensive sessions include lectures, discussions, group counseling, family education, treatment goal and life-goal planning. . . .

Outpatient Care. . . . designed to meet the needs of individuals who are not in need of hospitalization, but who are nonetheless experiencing problems in their lives connected to alcohol or drug abuse. The program provides both a more effective and more professional continuum of care in order to arrest the addictive process and to reduce relapse rate. The outpatient options include evaluation and referral, group and individual therapy, and counseling for families and spouses. . . services available to individuals who, having recently completed structured programs (i.e., Greene Hall), require follow-up care; individuals who have completed

program at least six months hence and need further treatment for relapse or relapse prevention; families and others associated closely with chemically dependent persons and who are suffering from the destructive forces of living in a chemically dependent environment.

Family Intervention Services. . . . provides preparation and training. . . . in intervening in the disease. . . to help them [chemically dependent person] deal with the situation constructively. The alcoholic, his family, and other concerned parties meet with one of the counselors to discuss and resolve their problems. Structured intervention techniques lead to treatment [getting the alcoholic to accept treatment]in nine out of ten cases (67:--).

In addition to the above treatment programs, IAI also schedules and encourages their clients/families to attend AA, Al-Anon, and Alateen meetings in their facility.

Children from Alcoholic Families

The Children from Alcoholic Families is a prevention/treatment program established to help high risk (susceptible to alcoholism) children of alcoholic families. This program does not adhere to any specific treatment philosophy; however, its primary goal is to stop the spread of alcoholism by "interrupting the intergenerational processes of alcoholism" (9:186,188). The focus of the treatment is on the children; however, parents are also active participants in the treatment process (9:188). The treatment approaches used include individual/group therapy, family therapy, educational group, aftercare group, and self-help groups (AA, Al-Anon, Alateen, and/or Alakid).

The Children from Alcoholic Families provides the following treatment programs:

Parents' Program. The parents are offered a two-pronged approach, a psychoeducational group and individual treatment for stress management. The parents' group is a forum for discussion of prevention strategies, role behaviors, family systems, and parenting education. . . at least one parent is required to attend. . . . If the alcoholic will not attend, work is done with the spouse to improve the family environment and possibly change the system. Individual treatment includes biofeedback [for promoting] relaxation.

Children's Program. The children experience alcohol education, socialization, and treatment for emotional and behavioral problems through a peer group modality. The intent of the group is that reasonable freedom of expression should exist without fear of reprisal, and rigidified role behavior should be unnecessary.

The goals of these groups are to: (1) let the children know they are not alone; (2) inform them that it is not their fault that their parents are alcoholics; (3) teach the children about the nature of addictions and the difficulty their parents have in achieving and maintaining sobriety; (4) reassure them that alcoholism is treatable; (5) help them learn about themselves and take care of themselves; (6) allow for expression of positive and negative feelings; (7) foster improved peer relationship skills; (8) teach problem-solving techniques; (9) evaluate the level of

coping skills, social skills, and overall function in conjunction with the family [used to determine appropriate aftercare or continued treatment].

Family Program. Each family has a family therapy session once a week for six weeks. Family therapy goals are established that are unique for each family. The goal of this component program is to allow the family to view the effects of alcoholism on each member and [on] the system as a whole. The family can then view the problem existing within the family system and begin to move from an unhealthy system to a healthy system. . . . the overall goal is movement toward a healthy system that produces children who are emotionally strong.

Aftercare Program. When the family members have completed the six week group and family sessions, an aftercare assessment is accomplished by gathering information from each counselor who is familiar with a family member, results of formal evaluations, and contacts with other sources in the community capable of providing a measure of social and emotional coping. The results of this assessment determine if the family member would benefit from further family therapy, inclusion in a long-term aftercare group, referral to self-help groups (i.e., Al-Anon, AA, Alateen, or Alakid). . . . (9:188-189).

In the book Alcoholism and the Family, authors Lawson, Peterson, and Lawson, state, "Treatment methods for alcoholism must include the children. . . ." (9:109).

OVERVIEW OF MILITARY REHABILITATION PROGRAMS

In Chapter Three, the author briefly traced the history of the Air Force Alcohol Abuse Control Program. Since the initial test of the inpatient Alcohol Treatment Center at Wright-Patterson AFB, the Air Force rehabilitation treatment programs have now grown to 10 regional Alcohol Rehabilitation Centers, and 141 base-level (Social Actions) outpatient rehabilitation programs (11:6). The TRI-Service Alcoholism Recovery Facility (TRI-SARF), a joint service treatment program, located at Bethesda, Maryland, also serves Air Force members and their families (61:36).

Also, there are many on and off base agencies (chaplain, Staff Judge Advocates, Security Police, Family Support Centers, etc.) and programs (FAST, AA, AL-Anon, Alateen, etc.) available to help alcoholics' families (61:1).

Rehabilitation Philosophy

The Air Force rehabilitation programs' philosophy is best described as a "multivariant" model, or multimodality approach to treatment of alcoholism (35:12-13; 61:3; 63:4-4). The Air Force therapeutic philosophy is based on the concept that "alcoholism is preventable and treatable" (63:3-1; 61:3-1; 62:--; 28:1-17). Furthermore, medical services defines alcoholism as a "progressive, non-compensable disease that affects the entire family . . . ." (61:1). Both AFR 30-2, "Social Actions Program," and AFR 160-36, "Medical Service Alcoholism Rehabilitation," stress the need to get the family of the alcoholic to participate in the alcoholic's treatment program.

- It is Air Force policy to prevent alcohol abuse and alcoholism among

its personnel and their family members. . . .

- Alcoholism is widely recognized as a family illness. As such, it is advisable to have the spouse and other family members of the patient participate in the patient's treatment program.

- Social Actions, together with the individual's commander, should make every possible effort to bring the family into the rehabilitation and recovery process. . . .

- Social Actions provides consultation, information, and guidance concerning drug and alcohol abuse to all Air Force members. . . and their families.

- Social Actions is one of a number of highly qualified agencies that can assist in restoring dysfunctional families to a functioning unit (63:--; 61:--).

Treatment Approaches

In 1975, the Department of Defense (DOD) contracted the System Development Corporation (SDC) to evaluate the DOD Alcohol Abuse Control Program. The researchers investigated various facets of the alcohol abuse control programs on thirty military bases (Air Force, Army and Navy), located world-wide (47:1-1). One of the areas evaluated was the types of treatment modalities (or approaches) used in these facilities. Table 3 lists the "most frequently used modalities, along with the percentage of Directors [Treatment/Rehabilitation] who indicate that they use each modality for inpatient or outpatient treatment" (47:4-6 - 4-7). This Table shows that family therapy is one of the most frequently used modality, and (of the 28 Directors of Treatment/Rehabilitation's records reviewed) 68% of the Directors indicate they use it for inpatients and 59% for outpatients (47:4-7). In contrast, when Directors of Treatment/Rehabilitation, medical, and non-medical program personnel were specifically asked in a questionnaire "how frequently various modalities are being used," group therapy and AA groups were reported as the most frequent (See Table 4.). Family therapy was listed as being "used less than half of the time" (47:4-125).

The conclusion made by SDC on the types of treatment modalities used was: "The most frequently and extensively used modalities are AA meetings, individual counseling, group therapy, and peer group discussions" (47:4-126).

EXAMINATION OF AIR FORCE REHABILITATION PROGRAMS

The Air Force Rehabilitation Centers (ARCs) provide alcohol treatment for military members/dependents, retired military members, and members of other services (19:9-12; 51:--; 63:--; 11:--). ARC is a 28-day inpatient program based on the therapeutic philosophy that "alcoholism is preventable and treatable" (62:7-16). The 10 rehabilitation centers use a variety of treatment approaches (techniques). For example, the ARC at Weisbaden, Germany, conducts group therapy, family therapy, an extended group therapy called "minimarathon," didactic seminars (topics include nutritional, medical, family, social and legal aspects of alcoholism), leaderless groups, occupational therapy and AA meetings (19:9-12; 62:--). Other ARCs use, in addition to those already

TREATMENT MODALITIES

Modality	% For In-Patients	% For Out-Patients
Individual Counseling	77	68
AA Meetings	77	64
Peer Group Discussions	73	32
Group Therapy (Directive)	68	36
Group therapy (Non-Directive)	68	45
Family Therapy	68	59
Antabuse	64	50
Educational Procedures	59	41
Chaplain Counseling	59	27
Social History	59	45
Recreational Therapy	55	5
Follow-Up Counseling	55	50
Reality Therapy	50	32
Recovered Alcoholic Counseling	45	27
Personality Questionnaire	45	23

N= 28 Directors

(Source: US Department of Defense: Task XI of a Study to Evaluate Department of Defense Alcohol Control Program. Defense Department Center, Defense Supply Agency, VA: System Development Corporation, 1975, p. 4-7.)

Table 3. Most Frequently Used Treatment Modalities

Modality	Frequency Rating
Group Therapy	4.31
AA Groups	4.30
Follow-Up Counseling	3.71
Individual Therapy	3.68
Reality Therapy	3.42
Recreational Therapy	3.17
Chaplain Counseling	2.95
Testing Techniques	2.87
Behavior/Operant Therapy	2.78
Rap Centers	2.76
Family Therapy	2.66
Occupational Therapy	2.57
Encounter Therapy	2.56
Transactional Analysis	2.43
Half-Way House	2.02
Tranquilizers	1.91
Psychodrama	1.91
Transcendental Meditation	1.50
Synanon Games	1.49
Aversive Conditioning/Shock	1.43

Scale: 1 = Never, 2 = Seldom, 3 = About half the time, 4 = Often, 5 = Usually

Directors (N = 35), Medical Program Personnel (N = 105), Non-Medical Personnel (N = 127)

(Source: US Department of Defense: Task XI of s Study to Evaluate Department of Defense Alcohol Abuse Control Program. Defense Department Center, Defense Supply Agency, VA: System Development Corporation, 1975, p. 4-125.)

Table 4. Ratings of Frequency of Use of Modalities

mentioned, individual psychotherapy, spouses groups, psychodrama, TA/Gestalt groups, relaxation therapy and 12-hour weekend marathon therapy (to include spouses). The primary therapy for families of alcoholics among all ARCs is family therapy (62:--). In his article, "Programs for the Treatment of Alcoholism," Captain (Dr.) Arthur R. Schramm, formerly of Wright-Patterson AFB, Ohio, comments on the importance of family therapy:

> Among the group therapies, family therapy should be considered. . . , inasmuch as relationships in the families of alcoholics are usually disturbed before the onset of drinking, and are further aggravated by drinking; many authors feel that it is imperative to establish therapeutic contact with family members, and they go so far as to say that without family therapy, chances for successful treatment of alcoholics are seriously diminished (40:397).

The active duty members, and family members who are dependent on alcohol, all participate in the same treatment regimen. Colonel Stuart Myers, Military Consultant to the Surgeon General in Clinical Social Work and Alcohol Rehabilitation, notes in his article, "Alcoholism Rehabilitation in the USAF," that from 1979 to 1982, a total of 326 military dependents (an average of 5% of total admissions) were admitted to various ARCs (35:23). The types of scheduled activities offered to patients will vary with each center; however, the activities listed in the Wilford Hall Medical Center ARC serves as an example:

- Group psychotherapy-5 hours per week.
- Two AA meetings, weekly-attendance is at a variety of chapters so that patients can appreciate the existence of various types of AA groups.
- AA discussion group-1 hour per week.
- Physical training-provided in conjunction with recreation training and with medical concurrence; held 2 to 3 times a week.
- Recreational therapy-teaches leisure time skills to the patients, 7 to 10 hours per week.
- Psychodrama-4 hours per week-designed to help patients with interpersonal relationships.
- Educational meetings-2 to 3 hours per week-films and discussions.
- Relaxation training-1 to 2 hours.
- Gestalt group-1 evening per week.
- Spouses group-held 1 night per week.
- Nonscheduled activities. . . designed to meet individual patient's needs.

  . . .
  -- Medical evaluation
  -- Psychological testing
  -- Individual counseling
  -- Social activities-special outings. . .
  -- Marital counseling (62:8).

The ARCs' Family Programs (for family of the alcoholic) normally last five days. According to the Director of the ARC at Andrews AFB, Maryland, "It's a very intense week of lectures, films and didactics, with emphasis on family interaction." And, "They are exposed to Al-Anon and Alateen" (25:8-9).

TRI—SARF's Family Program

The TRI-SARF's Family Program helps spouses and children "deal with the abnormal behaviors they have developed in an addictive relationship" (21:69). According to a former TRI-SARF graduate:

> Family members are asked to participate full time during the third and fourth weeks of the patient's treatment. Their activities are similar to those of the alcoholic, such as discussions, family group therapy sessions, lectures, and films. Many family members come believing they are going to learn how to help their spouses or parents stop drinking. They quickly realize they are there for their own program and begin to work on their own personal issues (21:69).

The biggest obstacle confronting the TRI-SARF Family Program is to get the family to come to treatment. The reason why families are hesitant to come is explained by the Director of the Family Program: ". . . spouses are guilt-ridden and think they are responsible for the alcoholic's drinking. They're afraid this is what will be discussed. Others are afraid of getting their hopes up, only to be disappointed when the alcoholic returns to drinking" (21:70).

The goals of the Family Program are to learn about the disease of alcoholism, how it has affected the alcoholic, and how the alcoholic has affected each family member. According to the Director of the Family Program the family's behaviors were "unpredictable," and, "each member was making up rules for life. It became a real seat-of-the pants existence" (21:70).

Social Actions' Alcohol Rehabilitation Program

The Social Actions Alcohol Rehabilitation is an outpatient program for active duty military members and their families. The rehabilitation program includes evaluation, education (primarily through Alcohol Awareness Seminar), counseling and referral (some bases have incorporated these services in the FAST program) (63:--; 11:19). A Social Actions officer at HQ AFMPC states there were 7,666 alcohol clients with families in FY 84, and of these, 1,729 families participated with the alcoholic in the program. The officer surmises the reason why family participation is low is "because it has to have the client's permission." He further added, "440 dependents were evaluated by Social Actions, but don't know how many actually underwent treatment--we don't keep record of these." "I tnink 95% of all dependents who have alcohol problems go to local off base treatment centers" (74:--). In FY 84, only 193 dependents were referred to other treatment programs (64:6).

In the Local Phase (treatment) of the alcohol rehabilitation program, the client (alcoholic, alcohol abuser, or problem drinker) is exposed to a variety of therapeutic techniques. These include, but are not limited to, individual and/or group counseling; marital or family counseling; occupational, recreational or legal counseling; medical or non-medical assistance; or a combination of services (63:4-4; 11:7). In this phase, the family of the client is asked to participate in the treatment program. "Social Actions, together with the individual's commander, should make every possible effort to bring the family into the rehabilitation and recovery process. The drug and alcohol abuse control counselor should contact family members only with the written permission of the rehabilitee" (63:4-4). However, if the client refuses for any reason, it is

documented in his/her rehabilitation folder.

After the client successfully completes the Local Phase, he/she is entered in the Follow-On Support (similar to aftercare) for at least 60 days, no more than one year. The purpose of Follow-On Support is to "assist clients by allowing them to demonstrate normal functioning in work and social situations, with a minimum of structured intervention" (11:7). The family is highly encouraged to participate in counseling sessions with the client during this phase: "It is imperative at this time to make other attempts to have the family involved if previous efforts have failed" (63:4-5). The therapeutic techniques normally used are individual and/or group counseling (11:7).

If the client is evaluated by Social Actions, the individual's commander, and the medical representative as requiring inpatient treatment (Alcohol Rehabilitation Center), then the Social Actions staff makes every effort to get the family involved in the inpatient program (63:4-5). However, before Social Actions can actually contact his/her family, a written permission must be given by the client. Families participating in inpatient programs are briefed on the following areas by the base medical representative and/or Social Actions counselor:

1. Location and description of the facility.

2. Population served.

3. Staff (counselors).

4. Treatment philosophy.

5. Clinical program, for example:
   - Group living.
   - Group or individual therapy.
   - Didactic groups.
   - Family counseling.
   - Other therapeutic efforts, such as occupational therapy and physical reconditioning.
   - Responsibilities (individual and group).
   - AA.
   - Aftercare and program follow-up (63:4-5).

COMPARISON OF PROGRAMS

All rehabilitation programs (except Children from Alcoholic Family) reviewed have either stated or implied that alcoholism is a disease (43:268; 67:--; 61:1; 66:--; 63:--; 62:--). All agree alcoholism is both preventable and treatable (66:--; 67:--; 9:188-89; 63:--; 61:--; 62:--). The TRI-SARF program also defines alcoholism as a disease, and both preventable and treatable (21:69-70). The Children from Alcoholic Families (CAF) has not adopted any specific treatment philosophy; however, it does consider alcoholism as preventable and treatable (9:188-189). In addition, all programs consider treatment of the family not only essential for the recovery of the alcoholic, but also for the entire family as well (66:--; 67:--; 9:--; 63:--; 61:--; 21:69-70). A spouse of an alcoholic attending TRI-SARF states, "I came here [family group] because

I was going to help my husband. I thought it was going to save our marriage and I was going to do anything for that. But I got in here and realized I have problems just as bad as he does. Now, I'm here for me" (25:9).

The above rehabilitation programs use a wide variety of treatment techniques or methods (multimodality). The primary treatment philosophy used on families of alcoholics is the AA model. Next comes the psychological model with emphasis on family therapy (or family/spouses group), followed by the social model (primarily through didactic/educational sessions).

The treatment techniques employed most often for families are family therapy, group therapy, didactic sessions, lectures, films, and regular, active participation in self-help groups (Al-Anon , Alateen, AA, and/or Alakid) Also among the 10 ARCs, TRI-SARF and Greene Hall, the primary treatment therapy used for families is family therapy (62:--; 66:--; 21:69-70). Among the outpatient programs (IAI and Social Actions), the primary therapy used for families was also family therapy/counseling (67:--; 11:--). The Children from Alcoholic Families used parents' group, peer group and family therapy (9:188-189). All programs used Al-Anon and Alateen as an adjunct to therapy.

In contrast, the programs differed in the treatment method used after the patient/family completes the inpatient phase of the program. At Greene Hall, patients/families attend regular aftercare groups. However, for long term follow-up care, the patient and his/her family were referred to other agencies (e.g., IAI). However, the ARCs return patients and their families back to their local rehabilitation programs for follow-up care. The follow-up service provided by ARCs is mainly administrative. They forward questionnaires to their patients periodically (each ARC has their own time-frame) to assess patients adjustment to family/work environments (62:--).

Chapter Five

CONCLUSIONS, FINDINGS, AND RECOMMENDATIONS

Based on the author's review of the literature, response from Air Force program (FSC, Social Actions, Family Matters office) directors and managers at base, Major Commands, Air Force Manpower and Personnel Center (AFMPC) and Air Staff levels, personal experiences and/or observations of the operation of the Air Force and civilian rehabilitation programs, the following conclusions and findings are made.

CONCLUSIONS

1. Alcohol abuse and alcoholism continue to be a significant health problem in the United States. It is considered the third leading health problem following heart disease and cancer. Various studies estimate the number of Americans affected directly with alcoholism range between 9 and 10 million. However, if families of the alcoholics are factored in, this figure could possibly increase by another 36 million. This estimate is based on the premise, derived by alcoholism researchers, that each alcoholic affects four other persons who are close to him/her--the family. Furthermore, this figure does not account for several million more who are indirectly affected by the alcoholic (i.e., friends, relatives, employers, supervisors, co-workers). Even though the exact number of people affected by alcoholism cannot be determined, evidence from police reports, hospital admissions, court hearings, family/alcoholism counselors, etc., supports this conclusion. And as one recovered alcoholic eloquently states, alcoholism takes "hostage of those that love them" (21:69).

2. The Air Force and DOD have taken great interest in assisting both family members dependent/addicted to alcohol, and families of alcoholics. The creation of the Family Assistance and Support Teams (FASTs) provided counseling and referral services for families affected by alcoholism. The changes to Air Force regulations (AFR 30-2, AFR 160-36), and amendments to DOD 1010.2, encouraged alcoholics' families to seek treatment, and to participate in the alcoholics' recovery process. The establishment of Family Support Centers (FSCs) provided crisis intervention, counseling, and referral services to families. Finally, the availability of advanced courses on the effect of alcoholism on the family systems, for Social Actions, FSC, FAST, and ARC members, are another examples of positive steps taken by Air Force and DOD to better meet the needs of the family.

3. Review of selected Air Force and civilian rehabilitation programs support, in general, that considerable similarities exist in the rehabilitation philosophy (treatment models) and treatment approaches (treatment settings, therapeutic philosophies, and techniques) applied to alcoholic family members and families of alcoholics. Based on the definition of alcoholism, the selected organizations (except Children from Alcoholics Families (CAF)) have either stated or implied that alcoholism is a disease.

All organizations agree on the family disease concept. The rehabilitation philosophy adopted by all organizations (except CAF) is best described as multivariant, or based on a multimodality approach to treatment of alcoholism. The treatment techniques employed specifically for families of alcoholics ranged from family therapy (existing in all facilities), to individual counseling/therapy sessions, didactic sessions, lectures, and films. A definitive conclusion as to the effectiveness of the above programs was not the intent of this research project. In order for the author to make such a conclusion would require access to data containing such information as success rates, relapse rates, alcoholics families participation rates, and follow-up care information, just to mention a few.

4. Alcohol abuse education participation of military families has continued to decline. For example, in the periods of January 1973 through June 1974, 45,961 dependents attended drug/alcohol abuse control education courses administered by Social Actions offices. The most recent statistics from USAF Drug/Alcohol Statistical Summary (FY 84) shows only 268 dependents attended the present Drug/Alcohol Education Seminars.

5. Family Support Centers are providing referrals and minimum counseling to families affected by alcoholism; however, the number of family members counseled or referred to on and off base agencies is not tracked. These families are grouped under the category of "family crises." Discussions with the Family Support Center Director and social worker indicate they keep no records of the exact number of families referred or counseled specifically for drug/alcohol abuse, nor are these data forwarded to Air Force Family Matters office (OPR) (58:--; 69:--). The Director also indicated the consolidated Air Force-wide FSC report does not break this data out separately (69:--).

6. The FAST program is not adopted on all bases. According to Social Actions officers at HQ AFMPC and Air Staff, "it is not a big driver" in Social Actions programs (74:--), and "FAST is still with us but it depends on the local conditions" (70:--).

FINDINGS

7. The types of problems experienced by families of alcoholics in the civilian communities are similar to those experienced in military communities. Studies on families of alcoholics link alcohol abuse with many domestic problems (spouse/child abuse), deaths, suicides, drug abuse, rapes, etc. Also, the studies indicate alcoholics cause or contribute to many emotional, mental, and physical problems experienced by family members. The author provides the following questions for future research on alcoholics' families: (1) Did the alcoholic or alcohol abuser create the family problems or just add to existing problems? (2) As a result of existing family problems, did the family blame their shortcomings on to the alcoholic (scapegoat)? (3) If the alcoholic is removed or treated, will this resolve the family's problems or compound them? and finally, (4) Who is to blame for the alcoholic's predicament: the alcoholic, the family, or both? There are many more questions of this nature. It is the general consensus of researchers and alcoholism counselors that many factors are involved in creating a dysfunctional family. Their view of alcoholism is that it is a disease that requires treatment, not just for the alcoholic but for the entire family.

8. Air Force rehabilitation programs are not attracting many families to

participate in the recovery process of their spouses who are admitted for treatment. For example, in FY 84, 7,666 alcohol clients/patients with families under went rehabilitation, only 1,729 families participated (69:--; 64:6). A Social Actions officer at at HQ AFMPC indicates the reason may be due to the requirement for a client to give a written permission before his/her family members can be contacted to participate (73:--).

9. Very few families experiencing alcohol problems are evaluated or referred for treatment, either on or off base. In the FY 84 Drug/Alcohol Statistical Summary, only 440 families were evaluated and of these, 193 were referred to other treatment programs or facilities (64:6). Also, from 1979 to 1982, a total of 326 dependents (an average of 5% of total admissions) were admitted to ARCs for treatment (35:23).

It is the belief of the author the reasons for low participation and admission rates of family members may be due not only to written permission required, but also to the perceived "stigma" attached to alcoholism. Also, the fear that involvement will somehow "hurt" the military spouse's career, and general distrust of the military's sincere desire to help alcoholics and their families. For example, in 1981, SRA Corporation conducted a survey to assess the attitudes and perceptions of military families towards various military agencies and organizations. One of the questions asked families was who they would seek for help for a personal or family problems. Even though alcohol abuse was not mentioned specifically as part of the problem, it is interesting to note that two agencies who provide assistance for alcohol problems (Social Actions and Mental Health) were the last two agencies families would contact (See Table 5.) (53:7-1 - 7-9). However, when asked if they were satisfied with their service, the majority responded favorably (See Table 6.) (53:7-7). Additionally, the study revealed several Air Force leaders responding to the surveys indicated "some concern about the stigma that surrounds certain agencies and organizations" (53:7-6). This survey was one of several assessment instruments used by Air Force planners to develop Family Support Centers.

10. The exact number of family members requiring treatment for alcohol problems, and families of alcoholics participating in ARCs and Social Actions programs cannot be determined. The FY 84 Drug/Alcohol Statistical Summary tracks family participation by "units"; "not by number of dependents" (64:6). Furthermore, the statistic does not break out the number of dependents treated or participating in ARCs or Social Actions programs by a specific rehabilitation facility.

RECOMMENDATIONS

The following recommendations are provided, not as a quick "panacea", but to encourage Air Force planners to broaden their effort to help families affected by alcoholism: (Note: recommendations' numbers correspond to those conclusions or findings that require action)

(4) Recommend renewed emphasis to educate the military families by encouraging participation in base and local community sponsored alcohol abuse education seminars and courses through such avenues as Newcomer Orientation programs, Drug/Alcohol Abuse Control Committees, Civilian Managers/Supervisors courses, base Professional Military Education (PME) courses, Federal Women's Programs, wives clubs, Family Services, Family Assistance Information Boards, and related

WHO WOULD BE SOUGHT OUT FOR HELP WITH A PERSONAL OR FAMILY PROBLEM

Families in PACAF

	Husbands	Wives	Single Parents
Friends	26%	30%	52%
Neighbors	3%	6%	7%
Parents/Relatives	40%	6%	7%
Job Supervisor	18%	11%	26%
Work Associates	10%	7%	15%
Chaplain	22%	28%	22%
Mental Health	6%	11%	11%
Social Actions	4%	6%	4%

Note: These percentages represent the number in each group who said they would be likely to seek out particular people for assistance. Since multiple responses were allowed, percentages exceed 100.

(Source: US Department of the Air Force. Family Support Center Resource Manual. The Pentagon, Washington, DC: HQ USAF/MPXHF, no date, p. 7-8.)

Table 5. Who Would Be Sought Out For Help

SATISFACTION WITH SOCIAL ACTIONS, MENTAL HEALTH, AND CHAPLAIN SERVICES:

Families in PACAF

	Very Dissatisfied	Dissatisfied	Mixed Feelings	Satisfied	Very Satisfied
Social Actions:					
Husbands	8%	12%	31%	41%	8%
Wives	4%	10%	23%	50%	13%
Single Parents	10%	5%	20%	43%	22%
Mental Health:					
Husbands	7%	9%	20%	55%	9%
Wives	5%	12%	16%	54%	13%
Single Parents	0%	14%	7%	68%	11%
Chaplain:					
Husbands	1%	3%	6%	66%	24%
Wives	1%	3%	6%	66%	24%
Single Parents	0%	2%	2%	61%	35%

N= 597 husbands, 597 wives, and 56 single parents. Interviewees were asked to indicate their degree of satisfaction with selected aspects of Air Force life.

(Source: US Department of the Air Force. Family Support Center Resource Manual. The Pentagon, Washington, DC: HQ USAF/MPXHF, no date, p. 7-7.)

Table 6. Satisfaction With Services

activities. Also, incorporate a block on the family disease concept in existing education and training courses (i.e., PME courses, civilian personnel sponsored courses, hospital inservice training, human development courses sponsored by Education offices, etc.). Finally, expand the current Social Actions drug/alcohol abuse courses offered to commanders/supervisors and non-supervisors to include increased information on the family other than what agency provides what services. Interview with a drug/alcohol counselor indicates the current lesson plan has "nothing in the curriculum dealing with the family" (72:--).

(5) Recommend Air Force Family Matters office (AFFAM) require FSCs to track the number of family members requiring assistance for alcohol-related problems by extracting this data from AF Form 2804, Family Support Center Agency Referral form. Also, recommend AFFAM revise the current Air Force-wide FSC report to indicate this data as reported from field units. Furthermore, provide this data to HQ AFMPC/MPCXO to incorporate into their drug/alcohol statistical summary report. By doing so, Air Force Alcohol Abuse Control Program's administrators and planners can better assess the impact alcohol abuse or alcoholism has on military families.

(6) Recommend research be conducted to evaluate the effectiveness of FAST programs. If FAST programs are no longer a viable program on most bases, then determine if FSCs are really meeting the objectives set forth in the FAST concept.

(8) Recommend during the client's intake interview that his/her spouse must also attend. Furthermore, require the spouse of the alcoholic to sign the intake interview to ensure he/she understands the importance of participating in the alcoholic's treatment program. Also, efforts should be made by Air Force Alcohol Abuse Control Program administrators to either change the requirement to obtain written permission, or research this problem to find a suitable alternative. Remember--the goal is to get the family involved in the recovery process of the client/patient.

(9) Recommend an Ad Hoc Task Group be established at Air Force level to thoroughly review the problem of getting families experiencing alcohol abuse problems to seek help from either on or off base rehabilitation programs. The goal of the Task Group should be to improve the quality of life for families affected by alcoholism.

(10) Recommend the USAF Social Actions Drug/Alcohol Statistical Summary be revised to incorporate the concerns expressed in this finding, and data included in the proposed AFFAM world-wide FSCs report. By adding this information, Air Force can accurately assess the impact alcohol abuse has on military families, and help determine what actions are required to meet families' needs.

SUMMARY

Overall, the Air Force has resources available to take care of the needs of family members dependent/addicted to alcohol, and families of alcoholics. However, there is still room for improvement.

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